

PREFACE

Health Care Excel, Incorporated, is a private, not-for-profit organization established for the purpose of providing clinically-based objective, and independent monitoring of the quality, appropriateness, and medical necessity of health care services. Our goal is to improve health care processes and outcomes, as well as the health status of target populations. Health Care Excel (HCE) performs effective quality assurance review, utilization review, medical data analysis, and quality improvement.

Health Care Excel, in its role as the Indiana Medical Policy and Review Services contractor, is responsible for the Prior Authorization (PA), Surveillance and Utilization Review (SUR), and Medical Policy (MP) business functions. The Prior Authorization Operations Manual has been developed to ensure the successful functioning of the PA department. Included are procedures, forms, reports, descriptions of the services requiring prior authorization, and other information. The manual also may be used as a reference for the Office of Medicaid Policy and Planning (OMPP), as well as the Surveillance and Utilization Review and Medical Policy departments, and others.

HCE's goal is to ensure that the Indiana Medical Policy and Review Services contract is managed effectively, is coordinated with other stakeholders and contractors, and provides excellent service to the State of Indiana. The Medical Policy and Review Services contract is under the oversight of the Office of Medicaid Policy and Planning, Indiana Family and Social Services Administration.

Note: Revisions to the Prior Authorization Operations Manual will be identified through the use of **shading** in the text and exhibits, and the use of a date code in the lower left-hand corner of each page.

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I. OVERVIEW

A. Indiana Medicaid Program and Prior Authorization Review Responsibilities for the Medical Policy and Review Services Contractor

The Indiana Family and Social Services Administration (FSSA) is the umbrella agency responsible for administering Indiana's public assistance program. FSSA is composed of the following agencies: Office of Medicaid Policy and Planning (OMPP); Administrative Services; Office of Information Technology Services; Division of Disability, Aging and Rehabilitation Services (DDARS); Division of Family and Children; and Division of Mental Health and Addiction. The Assistant Secretary for Medicaid Policy and Planning is responsible for administering OMPP. The oversight of the Medical Policy and Review Services contract has been delegated to the Director of Program Operations.

B. Objective of Prior Authorization

The primary objective of Prior Authorization (PA) is to serve as a utilization management measure allowing payment only for those treatments and/or services that are medically necessary, appropriate, cost-effective, and to reduce over-utilization and/or abuse of specified services.

C. Medicaid Management Information System (MMIS) and Systems Support for Prior Authorization

The Indiana Health Coverage Programs (IHCP) Management Information System is referred to as *IndianaAIM*. Systems support provided by *IndianaAIM* includes the following functions.

- ♦ Maintains all PA requests on-line (the system stores all PA requests regardless of their current status, e.g., under evaluation, approved, denied).
- ♦ Decrements PA units during claims processing.
- ♦ Maintains an authorization history for all members with a PA on file.
- ♦ Links PAs to relevant claims history against the approved PA.
- ♦ Maintains all PA administrative review and appeal information on-line.

- ◆ Produces a variety of daily, monthly, and quarterly reports for use by PA and State staff; reports provide information used to evaluate and improve the PA process and monitor the timeliness of PA processing.
- ◆ Produces approval, denial, and other status notifications sent to providers.
- ◆ Monitors IHCP approved home health services in coordination with Home and Community-Based Services (HCBS) plans of care (485B). Approved home health services indicate verification of plans of care (485B) which validate coordination with home and community-based services. Report PAU 0008-M is used to report monthly utilization of home health services requested versus approved home health services. The Prior Authorization Director will present statistical reports to OMPP in the PA monthly report.
- ◆ Provides an audit trail of changes to the PA file.
- ◆ The system supports authorization of dollars, units, or periods of time.
- ◆ Supports the 278 transaction for Providers to submit requests electronically.

Health Care Excel (HCE) will coordinate these functions with EDS, the contractor that maintains IndianaAIM. Through an array of meetings, and written communiqués, HCE and EDS will serve the Prior Authorization activities on behalf of the Indiana Medicaid program.

D. Prior Authorization Department

The Program Director for the Medical Policy and Review Services contract will oversee the Director of Prior Authorization. The Director of Prior Authorization will work closely with the Medical Director, the Director of Medical Policy, and the Director of Surveillance and Utilization Review to coordinate program activities to achieve the objectives of the program (see **Exhibit II-3** Coordination Activities). Key management staff will participate in weekly Operations Assessment Committee meetings to discuss issues of mutual interest, formulate actions, and evaluate action plans. This internal quality assurance and improvement function will promote fulfillment of contract responsibilities and responsiveness to the stakeholders.

Information on the department staffing is located in **Section II**.

E. Confidentiality Plan

Our employees, consultants, and reviewers will be subject to the Confidentiality Plan. All employees will be requested to initially sign, and reaffirm on an annual basis, understanding and compliance with the plan.

F. Consultants and Reviewers

Periodically there will be a need to involve physicians and other health care practitioners in the Prior Authorization program. The Medical Director will support the review activities through the recruitment, training, and ongoing support of physicians and other health care practitioners in the formulation of medical review criteria, case review, and associated activities. Peer reviewers will be consulted to render a medical judgment on the partial or full denial of services or payment resulting from the lack of documented medical necessity. Denials resulting from procedural errors by the provider will not be referred to the Medical Director. The PA Supervisor and/or the PA Director will review these denials.

G. Prior Authorization Review

The Indiana Administrative Code (IAC), 405 IAC 5, provides the rules under which the Prior Authorization department fulfills its functions. 405 IAC 5-3 sets forth the provisions under which Prior Authorization may be provided. Prior to providing any Indiana Health Coverage Programs (IHCP) service subject to prior authorization, the provider must submit a properly completed IHCP Prior Authorization request form via written, fax, 278 mode or telephone, and receive written notice indicating the approval for provision of the service. Approval will be given orally at the time of a telephone request. IHCP will not reimburse any IHCP service requiring prior authorization, which is provided without first receiving prior authorization. The provider is responsible for submitting new requests for prior authorization for ongoing services before the current authorization period expires in order to ensure that services are not interrupted. Prior Authorization is not a guarantee of payment.

Prior Authorization requests may be submitted in writing (via mail or fax), 278 mode, or by telephone. The PA department staff relies on established criteria at the first level of review. These criteria are utilized as screening guidelines and have been approved by the State. In addition, staff will use the portions of the IAC that delineate guidelines for the approval of services and supplies, and relevant written communiqués or other directives, written or expressed, as approved by the OMPP.

Cases that cannot be approved or modified by the PA reviewer, based upon written criteria, will be referred to a PA Supervisor or the PA Director for additional review. Professional consultants, who will evaluate cases based upon standards of practice and professional judgment, will perform the second level of review. Providers and members may appeal denials or modifications of services in accordance with 405 IAC 5-7-1.

In addition to the PA function, the department is responsible for processing administrative reviews of denied or modified services. This is an internal appeal process whereby providers may ask for a case to be reviewed by a person other than the original reviewer. Additional documentation may be submitted. The department is also responsible for the processing of appeals that will be heard by an Administrative Law Judge (ALJ).

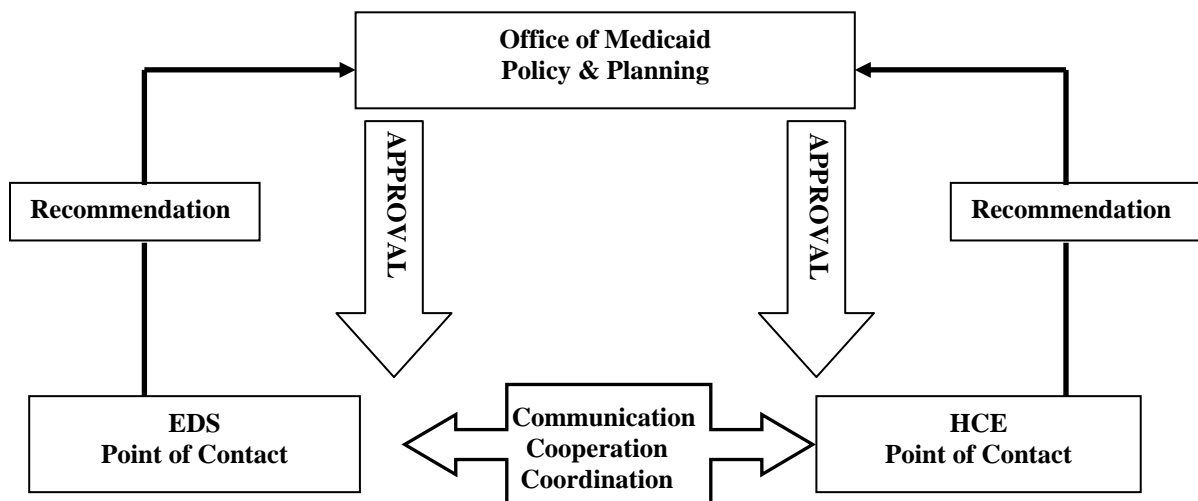
HCE has developed the Prior Authorization Operations Manual to be used by the Prior Authorization, the Surveillance and Utilization Review, and the Medical Policy departments, and for use as a reference for the OMPP. The manual contains information about the composition of the organization and the department, policies and procedures, information about the supplies and services requiring PA, forms, quality management activities, and HIPAA guidelines. It is intended to be a working document that will facilitate the prior authorization process, ensuring the quality and consistency of decisions.

The criteria to support the review process are provided in a supplemental manual. Other plans, which support PA, include an array of documents, such as provider manuals, Claims Resolution Manual, State IHCP program manuals, HCE Quality Management Plan, Customer Service Plan, contract work plan, Indiana Medical Policy and Review Services (IMPRS) Privacy Manual, annual business plan, and other operations manuals and plans.

II. ORGANIZATIONAL STRUCTURE, STAFFING, AND RESPONSIBILITIES

The Prior Authorization department will coordinate activities with the other business functions within Health Care Excel (Medical Policy and Surveillance and Utilization Review), with EDS, other contractors, and with the State. There will be regular meetings to discuss goals and objectives, evaluate processes, and to work together to make improvements in the program. The figure below represents the flow of information among HCE, EDS and the State, the principal partners in this process.

**FIGURE II-1
COMMUNICATION, COOPERATION, AND COORDINATION**



A. Prior Authorization Staff

The Prior Authorization (PA) department has been staffed to ensure the fulfillment of its functions and to provide optimal customer service to the State, providers, and IHCP members. The PA department consists of a director, two (2) supervisors, two (2) specialists, 16 reviewers, and 6.5 support staff. (Refer to **Figure II-2.**) All staff must achieve and maintain performance standards, and meet or exceed the position qualifications established by the State and HCE. (Refer to **Section VIII** for Quality Management activities.)

The management and supervision of the department is the responsibility of the **PA Director**. The PA Director is accountable for the overall functioning of the department and for the achievement of contractual goals.

PA Supervisors conduct the day-to-day oversight for the department staff, and may serve in the absence of the PA Director on specific issues to ensure department and contract responsibilities are achieved.

PA Specialists perform evaluations of PA services and assist in the resolution of complex cases through research and/or consultation with external experts (when appropriate). They are responsible for preparing cases for hearings and appeals, and representing the State at hearings. Specialists may make recommendations for program improvement.

PA Reviewers are responsible for reviewing and making determinations on PA requests based on written criteria, the Indiana Administrative Code, and other statutory and program regulations and guidelines. Reviewers also support the hearings and appeals process.

PA Support Specialists perform several duties involving written and faxed mail, data entry, organization of files, maintenance of department case files, and maintenance of calendars and tracking tools.

B. Responsibilities of the Prior Authorization department

Exhibit II-1 depicts the responsibilities assigned to Prior Authorization.

C. Primary Coordination with EDS

EDS holds the contracts for the Claims Processing and Related Services, and the Third-Party Liability. As the Medical Policy and Review Services Contractor, HCE has fundamental coordination responsibilities with EDS.

**FIGURE II-2
PRIOR AUTHORIZATION ORGANIZATIONAL CHART**

The organization chart depicts the PA department staffing and reporting structure.

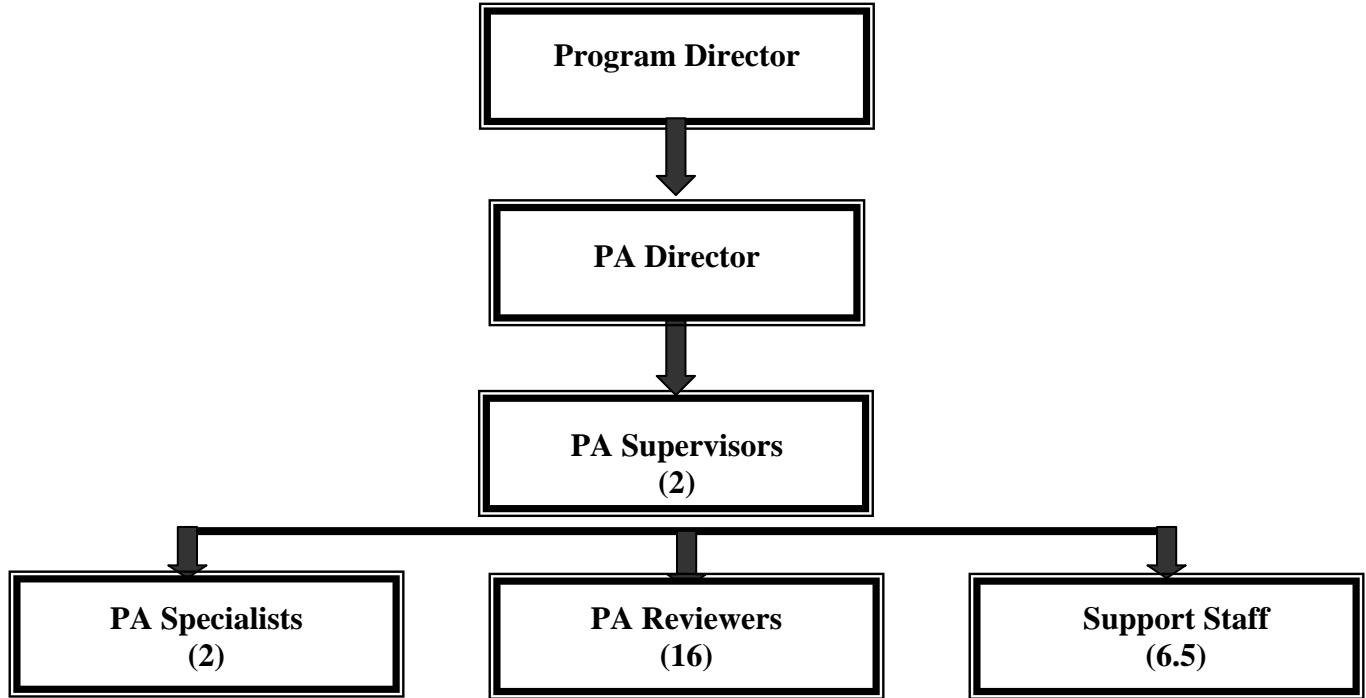


EXHIBIT II-1
RFP-3-45
Section 4

PRIOR AUTHORIZATION CONTRACT RESPONSIBILITIES

1. Receive PA requests and approve or deny the requests as appropriate.
2. Enter at least ninety-five percent (95%) of all PA requests into the IndianaAIM PA system on-line within two (2) business days of receipt. Enter the remaining percent within five (5) business days of receipt. The Contractor must develop and submit a report to the State to verify how this standard is being met.
3. Correctly disposition (i.e., approve, deny, or modify) prior authorization requests within ten (10) business days of receipt.
4. Develop and maintain medical criteria used to determine services that require prior authorization and make the criteria available to providers upon request. Criteria shall be provided within five (5) business days of the provider's request. The Contractor may charge providers for copies made of the criteria, but the cost shall not exceed the Contractor's cost to produce the copies.
5. Interface with providers on a regular basis to refine procedures for submission of PA requests to ensure that internal policies agree with changing practices in the provider community.
6. Ensure that non-covered or per diem-reimbursed services are not prior authorized.
7. For services that could potentially be coded with either of the coding systems (i.e., HCPCS or the NDC/UPC/HRI), establish and advise providers of their operant policy and what the requirements will be for assigning codes for such services.
8. Research, analyze, and evaluate all PA requests to ensure all medical facts have been considered prior to rendering a decision to approve or deny the request.
9. Conduct quality assurance reviews to ensure appropriateness of Medicaid PA analyst decisions.
10. Periodically review PA criteria against current practices to ensure appropriateness of PA decisions and to determine if changes to policy are required. Include representatives from the MCOs in the review discussions.
11. Ensure that authorized dollars and/or units are appropriately decremented from the PA file by paid claim.

EXHIBIT II-1 (continued)
RFP-3-45
Section 4

PRIOR AUTHORIZATION CONTRACT RESPONSIBILITIES

12. Maintain a sufficient number of toll-free (for Indiana and the contiguous states) PA phone lines and qualified personnel to staff the phone lines so that:
 - At least ninety-five percent (95%) of all calls are answered on or before the fourth ring.
 - No more than five percent (5%) of incoming calls ring busy.
 - At least ninety-five percent (95%) of calls are answered by a live person within two (2) minutes. (Hold time must not exceed two (2) minutes.)
 - The average hold time must not exceed thirty (30) seconds.
 - Call length is sufficient to ensure adequate information is imparted to the caller.
13. Staff PA phone lines from 7:30 a.m. to 6:00 p.m., local time, Monday through Friday (excluding State holidays).
14. Provide reports to monitor compliance with the above requirements.
15. Pro actively assist providers and recipients regarding PA issues.
16. Ensure PA staff utilizes well-defined processes and procedures for analysis and research for PA approvals.
17. Produce monthly reports of PA calls, type of call, and reports regarding line availability, incomplete calls, and disconnects.
18. Receive PA requests via telephone or fax, process requests in accordance with State regulations, enter caller responses on-line, and provide the authorization number or denial reason to the caller.
19. Provide adequate professional medical staff for staffing and managing the PA function, including medically knowledgeable PA analysts for processing requests and availability of licensed medical professionals to provide consultative services regarding all Medicaid-covered service types. The Contractor shall submit to the State a list identifying the individuals responsible for performing PA activities and the types of services for which each individual is responsible.
20. Purge old PA records according to State-specified criteria.

EXHIBIT II-1 (continued)
RFP-3-45
Section 4

PRIOR AUTHORIZATION CONTRACT RESPONSIBILITIES

21. Provide a minimum of three (3) fax machines dedicated to receipt of PA requests, with sufficient memory or buffers to handle multiple incoming transmissions. Statistics for receipt of PAs via fax are included in the monthly reports included in the Procurement Library. See Attachment D for details on how to obtain this information.
22. The Contractor will design PA forms or attachments as needed or define revisions to existing forms if changes are needed. Information should be provided to the core contractor for production of forms or attachments.
23. Prepare and maintain criteria used to make PA decisions. Provide copies of the criteria to providers upon request. The criteria shall be provided within five (5) business days of request. The Contractor may charge the provider no more than the cost of copying and mailing the requested materials.
24. Provide a monthly PA activity report to the State indicating, by type of service, the number of PA requests approved, modified and denied.
25. Prepare an annual work plan for the PA Unit. The plan shall be delivered sixty (60) calendar days before the end of the calendar year. The work plan shall include projects that will be performed and anticipated schedules and resources for the projects and shall specifically address the types of services requiring prior authorization that will be reviewed to evaluate the appropriateness on a quarterly basis. The plan should also include a summary of the activities performed the previous year. Upon completing each quarterly review, the Contractor shall provide the State with a report of progress made to date on the projects, a list of the services reviewed, and the Contractor's recommendations regarding the services that should not continue to require PA, or should be prior authorized and the rationale for its determination. The quarterly report shall be delivered to the State within thirty (30) days after the end of the quarter.
26. On a quarterly basis, the Contractor shall provide a trend analysis to the State to evaluate authorized services, the number of services rejected, the number of appeal requests by PA category, and the number and disposition of appeals. Upon completion of the qualitative and quantitative analysis, the Contractor shall provide recommendations to the State for suggested policy changes. The report shall be delivered within thirty (30) days of the end of the quarter.
27. Research and prepare appropriate, timely, accurate, and thorough responses to inquiries received from the State or providers. Inquiries from government officials require a written response within three (3) business days of receipt. All other inquiries shall be responded to within ten (10) business days of receipt.

EXHIBIT II-1 (continued)
RFP-3-45
Section 4

PRIOR AUTHORIZATION CONTRACT RESPONSIBILITIES

28. Provide staff to represent the State through written and personal testimony in PA appeal matters and court cases.
29. Provide research and documentation to support administrative hearings, appeals, and court cases.
30. On a quarterly basis, initiate a review of administrative reviews, hearings, and appeals from the previous quarter to determine if providers are submitting sufficient information for making appropriate PA decisions. The analysis shall include evaluating administrative reviews to determine how many result in a reversal, denial, or modification. Upon review completion, findings will be provided to the State that includes potential policy change recommendations to correct problems.
31. Attend PA administrative hearings and appeal hearings.
32. Provide necessary staff to attend meetings (provider association meetings, etc.) on an as-needed basis.
33. Refer instances of suspected fraud/abuse to the SUR unit.
34. Meet at least monthly with the SUR Unit and Medical Policy Unit to ensure coordination among the units. Coordinate with the Core Contractor on PA issues at least monthly or as determined to be necessary.
35. Implement a quality assurance process and establish procedures to periodically sample and review dispositioned PA requests to determine if PA policy and procedures are being followed.
36. Review and approve hospice authorization requests in accordance with State instructions and process the required paperwork, assuring the proper completion and that appropriate signatures are present when required.

EXHIBIT II-2
RFP-3-45
Section 4

STATE RESPONSIBILITIES

Note: The State reserves the right to waive the review and approval of Contractor work products.

1. Review and approve all PA error messages and the content of notification letters.
2. Approve the format of all PA request forms and related material.
3. Specify PA record purge criteria.
4. Work with the Contractor to confirm content, format, and expectations for reports prepared by the Contractor.
5. Specify and approve the types of services that may be requested by phone, fax, or other electronic inquiry.
6. Conduct monitoring to ensure that PA decisions are correct and appropriate.
7. Provide policy and procedure research, development, evaluation, and rule promulgation for new rules.
8. Approve prior authorization requests for services not otherwise covered under the State's Medicaid plan but determined to be medically necessary by an EPSDT provider for an EPSDT-eligible child.

EXHIBIT II-3
RFP-3-45
Section 4

COORDINATION ACTIVITIES

1. Develop and maintain coordination methods to provide PA information to the Medical Policy Unit, SUR Unit, the Core Contractor, Waiver Unit staff, and other contractors, including the Managed Care Organizations, as necessary to support the Medicaid program.
2. Coordinate and establish protocols for call transfers.
3. Work with the Core Contractor to resolve claims issues regarding PA.
4. Coordinate activities with the Medical Policy and Review Services Contractor to develop standards regarding PA assignment. Include standards cited to document decision appropriateness.
5. Proactively provide feedback to the Core Contractor and other identified contractors as necessary regarding PA issues.
6. Develop, update, and submit PA information (e.g., appropriate telephone numbers and information on how to obtain hard copies of PA criteria, etc.) to the Core Contractor for inclusion in the provider manual.
7. Review, verify, and deliver to the State, within thirty (30) calendar days of the following month, a report summarizing the Contractor's PA activities performed for the preceding month, including the nature of the PAs (psychiatry, neurology, etc.) and the numbers of each (including which were denied and which were approved).
8. Prepare materials related to PA, subject to State approval, for inclusion in bulletins, newsletters, manuals, etc., prepared and issued by the Core Contractor. The Medical Policy Contractor shall forward the approved materials to the Core Contractor on a mutually agreed-upon schedule. Report findings to the State on a monthly basis.